

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05204

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince Georges
 City or town Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 mos., 1 day
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 9 mos., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1215 Holbrook Street, N. E.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

LUCIA ARMALY

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Michael Armaly
 7. Birth date of deceased (mo., day, yr.) June 29, 1907 6. (c) If alive, give age 40 years
 8. AGE: Years 39 Months 39 Days 11 If less than one day 27 hrs. _____ min. _____

9. Birthplace Italy
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business ---

FATHER 12. Name Cisidio Leone
 13. Birthplace Italy
 MOTHER 14. Maiden name Lucia Rufo
 15. Birthplace Italy

16. Informant Deceased
 Address _____
 17. Burial Date thereof 6/25/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____
 Location Washington DC
 18. Funeral director Indythy Hanlon
 Address 641 - H St. N. E.

19. June 25, 1947 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 25 1947 at 8 55 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT. 23 1946 to JUNE 25 1947
 and that I last saw him alive on JUNE 25 1947

Immediate cause of death Pulmonary Tuberculosis
 DURATION 11 mo.

Due to Tuberculosis of Bladder 2 yr 3 mo.

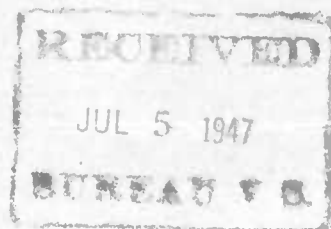
Due to _____
 Other conditions _____
 (Include pregnancy within 8 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of Injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinucane MD
 M. D. or other _____
 Address Glenn Dale, Md. Date signed 6/25/47



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05205
246

1. PLACE OF DEATH:

County... PRINCE GEORGES

City or town... RIVERDALE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 MONTHS

Hospital, institution, or street address where death occurred:

4504 OLIVER ST.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... PRINCE GEORGES

City or town... RIVERDALE
(If outside city or town limits, write RURAL and give nearest town)Street No. 4504 OLIVER ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MARY A. BAUR

3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOW

8.(b) Name of husband or wife

FRANK J. BAUR

7. Birth date of

deceased (mo., day, yr.)

JULY 9, 1883

8.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

63

hrs. min.

9. Birthplace

WASHINGTON, D.C.
(Town, county, and state)

10. Usual occupation

RETIRED

11. Industry or business

U.S. GOV'T.

FATHER

12. Name

WILLIAM KIGMAN

13. Birthplace

MARYLAND

MOTHER

14. Maiden name

ALICE KELLY

15. Birthplace

WASH. D.C.

16. Informant

Mrs. Marie Hoggatt
Address Rockville Pike, Rockville, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

6-27-47
(month) (day) (year)

Cemetery or crematory

ARLINGTON CEMETERY

Location

ARLINGTON, VA.

18. Funeral director

Francis J. Boelling
Address 3821-14th St. N.W., Wash. D.C.

19.

(Date rec'd by registrar)

June 26 1947 James Sever

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1947 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 14 1942 to 6-26 1947

and that I last saw him alive on 6-25-47 19

Immediate cause of death

Carcinoma of

DURATION

Due to

Carcinoma of rectum

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Clum M.D.
Address 14th St. N.W. Date signed 6-26-47

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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JUN 27 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05206

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George
City or town Bowie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
City or town Bowie, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war none

3. (a) FULL NAME

Larlian Mary Beall

3. (b) Social Security Number

4. Sex F. 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife George W. Beall
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Nov 22, 1854
8. AGE: Years 27 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Bowie Maryland
(Town, county and state)

10. Usual occupation Housewife

11. Industry or business none

12. Name John Scott

13. Birthplace Bowie Maryland

14. Maiden name Anne Mally

15. Birthplace Bowie Maryland

16. Informant Mrs Potter

Address 2817 Hainesville St. SE.

17. Burial Date thereof _____ (month) (day) (year)
(Burial, cremation, or removal. Which?)

Cemetery or crematory Secrett Deat

Location Bowie Md

18. Funeral director W. W. Chambers

Address 5801- Cedarland Ave, Riverdale Md.

June 23 1947 Mrs J. W. Gingling
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947 at 7:05 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1947 to June 23 1947

and that I last saw him alive on June 22 1947

Immediate cause of death Coronary Thrombosis DURATION _____

Arteriosclerosis

Due to _____

Due to _____

Other conditions Hypertensive

Myocardial infarction

due to chronic passive congestion of lungs

Major findings of operations (1/23/47)

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. M. Warren MD M. D. or other _____

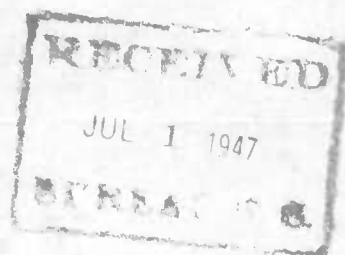
Address Lanier Date signed 6/23/47

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05207

93d

Reg. Dist. No. 230

1. PLACE OF DEATH: PRINCE GEORGES
 County.....
 City or town..... BERWYN
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 yrs
 Hospital, institution, or street address where death occurred:
R.F.D.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
Md. State..... County PRINCE GEORGES
 City or town..... BERWYN
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME RICHARD BREADEN

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced WIDOWED

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) APRIL 28, 1876 6. (c) If alive, give age..... years

8. AGE: Years 71 Months 1 Days 14 If less than one day..... hrs. min.

9. Birthplace DENBIGH, WALES GR. BRITTON
 (Town, county, and state)

10. Usual occupation RETIRED GOV'T EMPLOYEE

11. Industry or business U.S. GOV'T.

FATHER 12. Name William Henry Breaden

13. Birthplace Denbigh, Wales

MOTHER 14. Maiden name Margaret — Breaden

15. Birthplace Denbigh, Wales

16. Informant RICHARD C. BREADEN

Address 8 E. GRANVILLE DRIVE, SILVER SPRING, MD.

17. Burial Date thereof JUNE 13, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory ST JOHN'S EPISCOPAL CHURCH CEM.

Location BELTSVILLE, MD.

18. Funeral director Wm. J. Smith

Address 505 Washington Blvd., Laurel, Md.

19. June 11, 1947 John O. Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 11, 1947 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/9/1876 to June 11, 1947

and that I last saw him alive on June 11, 1947

Immediate cause of death Coronary Thrombosis DURATION 6 Mos

Due to Arteriosclerosis 5 yrs

Due to Arteriosclerosis

Other conditions Arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Warrick M.D.

Address Laurel Date signed 6/11/47

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JUN 16 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 05208
 Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town Glenn Dale, Maryland (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months, 27 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 3 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County _____
 City or town Washington Army Hotel
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Salvation Army Hotel
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

BROWN, GEORGE WILBUR

3. (b) Social Security Number

249-09-2676

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Rivannah Brown

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1915 6. (c) If alive, give age ? years

8. AGE: Years 31 Months 8 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Owensburg, South Carolina
 (Town, county, and state)

10. Usual occupation Helper on truck, Brewing Co.

11. Industry or business _____

12. Name George Brown13. Birthplace Columbia, S.C.14. Maiden name Carrie Rush15. Birthplace ? South Carolina16. Informant deceased

Address _____

17. Removal Date thereof June 1, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location to Washington, D.C.18. Funeral director L. E. Munnell & SonAddress 1337-10th St. N.W. Wash. D.C.

19. June 1, 47 Rowland S. Philips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 1 1947 at 6:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 5 1947 to JUNE 1 1947 and that I last saw him alive on JUNE 1 1947

Immediate cause of death Pulmonary Tuberculosis DURATION 4 mo.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

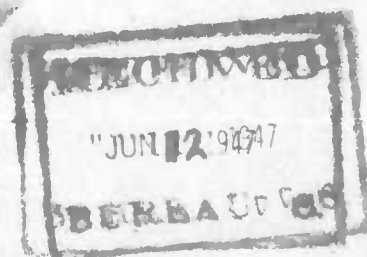
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Finucane MD M. D. or other _____

Address Glenn Dale Md. Date signed 6-1-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05209

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County... Prince George's
 City or town... Farmount Heights
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35+ years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Prince George's
 City or town... Farmount Heights
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 602-59th Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war... —

3. (a) FULL NAME

CARDOZO, HELEN ELIZABETH BELL

3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife CARDOZO, FRANCIS JAS.
Deceased 6. (c) If alive, give age 1878 years
 7. Birth date of deceased (mo., day, yr.) 1878
 8. AGE: Years 69 Months — Days — If less than one day — hrs. — min. —

9. Birthplace Washington D.C.
 (Town, county, and state)
 10. Usual occupation Housewife

11. Industry or business —
 12. Name BELL STEPHEN
 13. Birthplace Prince Georges Co Maryland
 14. Maiden name FLETCHER, MARY
 15. Birthplace Maryland

16. Informant BELL, RACHEL E.
 Address 1222 Kanyon St N.W. D.C.

17. Burial Date thereof June 9, 47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Woodlawn Cemetery
 Location Washington D.C.

18. Funeral director Robert & S. McGuire
 Address 1820-9 St. N.W.

19. June 7 19 47 Carrie F. Campbell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 19 47 at 5:00 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 19 47 to June 7 19 47
 and that I last saw her alive on June 7 19 47
 Immediate cause of death Cerebral arterio
sclerosis (chestory) 2 1/2 yrs
 Due to Generalized arterio
sclerosis 4 yrs
 Due to —
 Other conditions Coronary insufficiency 2 mo
 (Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —
 Autopsy results —
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide — Date of —
 Where did injury occur? — (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) —
 Means of injury — Injured at work? —

Theodore Pinckney, M.D.
 23. SIGNATURE 4832 Deane Ave N.E. M.D. or other —
 Address Washington, D.C. Date signed 6/7/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 10 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George'sCity or town Cheverly, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 hrs. 30 Minutes

Hospital, institution, or street address where death occurred:

Prince Georges General HospitalHow long in hospital or institution? 6 hrs. 30 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Maryland Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 6503 E. Street
(If rural, give LOCATION)

2.(c) If veteran, name war

3. (a) FULL NAME

Ethel Carter

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife James Carter

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 26, 1890

8. AGE: Years Months Days If less than one day

57

hrs. min.

9. Birthplace Virginia

(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Lee Wheelhouse13. Birthplace Virginia14. Maiden name Acelia Wall15. Birthplace Virginia16. Informant Hospital Records

Address

17. Transportation Date thereof June 13, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Richmond, Va.18. Funeral director W. Warren TaltavullAddress 436-7th St. S.W. Wash. D.C.19. 6/12 19 47 Amanda Douez

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 19 47 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Intra cranial hemorrhageCardio vascular renal disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results As stated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner

23. SIGNATURE James M. D. or otherAddress Forestville, Md. Date signed 6/12/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

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JUN 14 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05211

Reg. Diat. No. *245*

1. PLACE OF DEATH:

County *Prince Georges*
 City or town *Riverdale*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *37 yrs.*
 Hospital, institution, or street address where death occurred:
4711 Sheridan st.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Ind* County *Pr. Geo.*
 City or town *Riverdale*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *4711 Sheridan st.*
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

CHARLES FRANKLIN CASTELLA

3.(b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*
 6.(b) Name of husband or wife *Jennie M. Castella*
 7. Birth date of deceased (mo., day, yr.) *April 5, 1874*
 6.(c) If alive, give age *67* years
 8. AGE: Years *73* Months Days If less than one day
 hrs. min.

9. Birthplace *Montreal, Canada*
 (Town, county, and state)
 10. Usual occupation *Telegraph operator (retired)*
 11. Industry or business *Postal Telegraph*
 12. Name *Christophe Castella*
 13. Birthplace *England*
 14. Maiden name *Rachael Willment*
 15. Birthplace *Canada*

16. Informant *Charles C. Castella*
 Address *4711 Sheridan St., Riverdale, Ind.*
 17. *Burial* Date thereof *June 14, 1947*
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Comotory or crematory *St. Lincoln*
 Location *Colmar Manor Ind*
 18. Funeral director *J. Gascho Sons*
 Address *Hyattsville, Md.*
 19. *June 14* 19*47* *James Severy* Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *JUNE 11, 1947* at *3:50 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
SEPTEMBER 10, 1946 to *JUNE 11, 1947*
 and that I last saw him alive on *JUNE 11, 1947*

Immediate cause of death

Myocardial failure

DURATION

2 weeks

Due to *Chronic cardiovascular renal disease* ? years
 Due to

Dthor conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L. Louis Mendel, M.D.
 M. D. or other
 Address *College Park, Md.* Date signed *6/12/47*

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JUN 16 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05212 234

1. PLACE OF DEATH

County Pr Geo
City or town Broad Creek
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 8
Stay in hospital or inst. (yrs., or mos., or days) 49 yrs.
Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Pr Geo
City or town Broad Creek Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 7100 Livingston Rd, SE
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR Mar 20 DC

3. (a) FULL NAME

Mary Guy Clark

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Egbert Clark
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Dec 19 1877

8. AGE: Years 69 Months _____ Days _____ It less than one day _____ hrs. _____ min.

9. Birthplace Oxon Hill Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Packman Talbot

13. Birthplace MD

14. Maiden name Anna Eliza Cissell

15. Birthplace MD

16. Informant Egbert Clark

Address 7100 Livingston Rd SE

17. Burial Date thereof June 17-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Southland, Md.

18. Funeral director Arthur E. Simmons Jr.

Address 2007 Nichols Ave SE

19. June 14 19 47 Howard J. Beall
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1947 6:20 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1937 to June 14 1947
and that I last saw her alive on June 13 1947

Immediate cause of death myocarditis
acute congestive failure
Due to arteriosclerosis
Due to _____

Other conditions Coronary Atherosclerosis
(Include pregnancy within 3 months of death)

Major findings: Di operations
Di autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? now (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE E W Schwartz MD
M. D. or other MD
Address 1225 Talbot Ave Date signed 6/14/47

MARGIN RESERVED FOR BINDING

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 19 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05213 231

1. PLACE OF DEATH:

County Prince George's
City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days and 35 minutes
Hospital, institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution? 3 days and 35 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6203-Kilmer Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

ANNA COTSONIS

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
B. (b) Name of husband or wife Harry Cotsonis
7. Birth date of deceased (mo., day, yr.) June 28, 1863 6. (c) If alive, give age _____ years
8. AGE: Years 64 Months 0 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Greece
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. Name O. Sohoh
13. Birthplace Greece
14. Maiden name Mary Psaltis
15. Birthplace Greece

16. Informant Mr. Alexander Cotsonis (Son)
Address Same

17. Burial Date thereof 7/3/47
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery or crematory St. Lincoln Cem
Location The N. V. Home Co

18. Funeral director 2901-14 St. NW
Address 7/1 47 Amanda Downey

19. 7/1 47 Amanda Downey
(Date rec'd by registrar) Register

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1947, at 7:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6, 1947 to June 30, 1947
and that I last saw him alive on June 30, 1947
Immediate cause of death Cerebral Hemorrhage - Hypertension DURATION 6/29/47
Diabetes mellitus
Due to arterio-sclerotic cardio-renal disease
Due to _____
Other conditions cholesterolemia - appendicitis 6-29-47
(Include pregnancy within 3 months of death)
Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE George J. Hager M. D. or other _____
Address 3717-38th Ave Date signed 6/30/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 2 1947

BUREAU V. B.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05214

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 mos., 1 day
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution? 8 mos., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D. C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1526 C. Street, S. E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

FREDRICK D. CUNNINGHAM

3. (b) Social Security Number

577-01-8887

4. Sex Male	5. Color or race Colored	6. (a) Single, married, widowed, or divorced Married	
6. (b) Name of husband or wife..... Queenie Jackson			
7. Birth date of deceased (mo., day, yr.) June 21, 1912			
8. AGE: 34	Years 34	Months 11	Days 28
If less than one day hrs. min.			
8. Birthplace..... Lawrence, South Carolina (Town, county, and state)			
10. Usual occupation..... Red Cap			
11. Industry or business..... Union Station			
FATHER	12. Name..... Henry Cunningham		
	13. Birthplace..... South Carolina		
	14. Maiden name..... Lillian Fuller		
MOTHER	15. Birthplace..... South Carolina		

16. Informant..... Deceased			
Address.....			
17. Removal		Date thereof..... 6/9/47	
(Burial, cremation, or removal. Which?)		(month) (day) (year)	
Cemetery or crematory.....			
Location..... Washington D.C.			
18. Funeral director..... Matwan + Sealey Inc.			
Address..... 424-R St N.W.			
19. 6/9 47 Rowland S. Philips Registrar			
(Date rec'd by registrar)			

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 9 th 1947, at 7 ³⁵ A. M.	DURATION 11 mos.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 28 th 1946 to June 9 th 1947 and that I last saw him alive on June 9 th 1947	
Immediate cause of death..... Pulmonary Tuberculosis	
Due to.....	
Due to.....	
Other conditions.....	
(Include pregnancy within 8 months of death)	
Major findings of operations.....	
Autopsy results.....	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide.....	Date of.....
Where did injury occur?.....	(City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....	
Means of injury.....	Injured at work?
23. SIGNATURE..... Daniel Leo Finucane M.D.	
Address..... Glenn Dale, Md. Date signed..... 6/9/47	

RECEIVED

JUN 18 1947

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

05215

CERTIFICATE OF DEATH

Reg. Dist. No.

242

1. PLACE OF DEATH:

County Prince George's
 City or town allentown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, institution, or street address where death occurred:

6000 Temple Hill Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town allentown
(If outside city or town limits, write RURAL and give nearest town)Street No. 6000 Temple Hill Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Margaret Halkin

3. (b) Social Security Number

4. Sex Female5. Color or race White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Robert Halkin

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) January 11, 18608. AGE: Years 89 Months 0 Days 0 If less than one day
..... hrs. min.9. Birthplace England
(Town, county, and state)10. Usual occupation house

11. Industry or business

12. Name Thomas Morton13. Birthplace England14. Maiden name J. Alexander15. Birthplace England16. Informant Elinor H. WhitworthAddress 6000 Temple Hill Rd17. Burial Date thereof June 4, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar Hill CemeteryLocation Switland Md.18. Funeral director J. William Lewis Sons CoAddress 300-484 N.E. Washington D.C.19. 6/3 1947 Amanda Seung
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1947 at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 18....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death..... DURATION

UremiaDue to Cardiovascular renaldisease

Due to.....

Other conditions fracture of left armand forearm

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5-4-47Where did injury occur? allentown (City or town) Pr (County) MD (State)Injured at home, farm, industry, public place (where?) homeMeans of injury Fall down cellar Injured at work? No23. SIGNATURE Wesley H. Harkins M. D. or otherAddress allentown Date signed 6-5-47

RECEIVED

JUN 9 1947

BUREAU 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131A

CERTIFICATE OF DEATH

 05216
 Reg. Dist. No. *ms*

1. PLACE OF DEATH:

County *Prince George*
 City or town *Riverdale*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *9 days*
 Hospital, institution, or street address where death occurred:
Leland Memorial Hospital
 How long in hospital or institution? *9 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *D.C.* County _____
 City or town *Washington*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *4321 - 2nd St. N.W.*
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Viola Catherine Deaton

3. (b) Social Security Number

4. Sex *female* 5. Color or race *white* 6.(a) Single, married, widowed, or divorced *widowed*
 6.(b) Name of husband or wife *Francis Lincoln Deaton*
 7. Birth date of deceased (mo., day, yr.) *Oct. 13, 1865* 6.(c) If alive, give age _____ years
 8. AGE: Years *81* Months *8* Days *3* It less than one day _____ hrs. _____ min.

9. Birthplace *Yellow Springs, Ohio*
 (Town, county and state)

10. Usual occupation *Retired*

11. Industry or business *practical nurse & Teacher*

12. Name *James William Welch*

13. Birthplace *Green County, Ohio*

14. Maiden name *Viola Catherine Higgins*

15. Birthplace *Hillsboro, Ohio*

16. Informant *Leland Memorial Hospital Record*
 Address *Riverdale, Md.*

17. Removal *Removal* Date thereof *June 16, 1947*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Mc Kandree*

Location *Miami Co. Ohio*

18. Funeral director *S.H. Norris Co.* *Washington, D.C.*

Address *2901-14th St. N.W.*

June 16 1947 James Sevy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *June 16 1947* at *11:50 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *June 2 1947* to *June 16 1947*
 and that I last saw him alive on *June 16 1947*

Immediate cause of death *uremia* DURATION *5 days*

Due to *Chronic nephritis* ?

Due to *General arteriosclerosis* ?

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

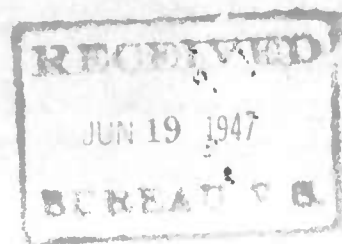
Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *L. W. Mahin M.D.* M. D. or other

Address *Riverdale, Md.* Date signed *6-16-47*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH: *Pro Geo Co*
 County *Riversdale Ind.*
 City or town *Riversdale Ind.*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *Ind* County *Pro Geo Co*
 City or town *Riversdale Ind*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *5006 Rittenhouse st*
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME *William Peter Slockendorf* 3. (b) Social Security Number

4. Sex *Male* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *married*
 6. (b) Name of husband or wife *Katherine Slockendorf*
 6. (c) If alive, give age *41* years
 7. Birth date of deceased (mo., day, yr.) *May 12, 1887*

8. AGE: Years *60* Months *-* Days *16* If less than one day
 hrs. min.

9. Birthplace *Chicago Illinois*
 (Town, county, and state)

10. Usual occupation *Retired Dressman*

11. Industry or business

12. Name *Peter John Slockendorf*

13. Birthplace *Chicago Ill*

14. Maiden name *Helen Marie Meter*

15. Birthplace *Cleveland Ohio*

16. Informant *Katherine Slockendorf*

Address *Riversdale Ind.*

17. Burial Date thereof *June 11, 1947*
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory *Arlington Cemetery*

Location *Arlington Va*

18. Funeral director *F. Gasche sons*

Address *Hyattsville Ind.*

19. *June 10* 19*47* *James Sever*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *June 8* 19*47* at *5:15 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death

Coronary Occlusion Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, "I" in the following:

Accident, suicide, or homicide Date of

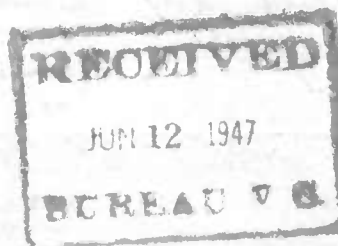
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *John J. Maloney M.D.*

Address *Cherry-Hyattsville Md* Date signed *6-9-47*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince Georges
 City or town Laurel, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Linda Diane Dustin

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

JUNE 8, 1947.

B. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

5

hrs.

min.

9. Birthplace

Laurel, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

NORMAN DUSTIN

13. Birthplace

BURTONSVILLE, Md.

MOTHER

14. Maiden name

VIRGIE MILLS

15. Birthplace

VIRGINIA

16. Informant

NORMAN DUSTIN

Address

BORTLER ROAD SILVER SPRING, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

June 14, 1947
(month) (day) (year)

Cemetery or crematory

Union Cemetery

Location

Burtonsville, Montgomery Co., Md.

18. Funeral director

Address

505 Washington Blvd. Laurel, Md.

19.

(Date rec'd by registrar)

19

M. Brachear

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

6-131947, at 1:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6 8

to

6 131947

and that I last saw him alive on

6 13 47

Immediate cause of death

dehydrationHeat exhaustion

DURATION

1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. P. Warner, M.D.

M. D. or other

Address

Laurel, Md.Date signed 6-13-47

RECEIVED
JUN 17 1947
BUREAU 95

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05219

Reg. Dist. No. *245*

1. PLACE OF DEATH:

County *Prince Georges*City or town *Hyattsville*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *2 yrs.*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Ind.* County *Pr. Geo.*City or town *Hyattsville*
(If outside city or town limits, write RURAL and give nearest town)Street No. *6150 - 42nd Ave*
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

HATTIE C. GEREN

3. (b) Social Security Number

4. Sex *Female*5. Color or race *White*6. (a) Single, married, widowed, or divorced *Married*6. (b) Name of husband or wife *Reinsey C. Geren*7. Birth date of deceased (mo., day, yr.) *Nov 1, 1885*6. (c) If alive, give age *years*8. AGE: Years *61* Months *0* Days *0* If less than one day *hrs. min.*9. Birthplace *Quinton New Jersey*
(Town, county, and state)10. Usual occupation *Dr. Home*

11. Industry or business

12. Name *Louis Patton*13. Birthplace *Carroll Rockhill*14. Maiden name *R. D. J.*15. Birthplace *Pr. Geo.*16. Informant *Reinsey C. Geren*Address *6120 - 42nd Ave Hyattsville Md*17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof *7-2-47*
(month) (day) (year)Cemetery or crematory *Geo. Wash. Mem. Cem.*Location *Riggs Rd. E. of Pk. Co. Md.*18. Funeral director *W. H. H. H. Sons*Address *Hyattsville, Md*19. *July 2* 19 *47* *Janus Seren*
(Date read by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *June 30* 19 *47* *26* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 *40* to *June 30* 19 *47*and that I last saw *u* alive on *June 30* 19 *47*Immediate cause of death *Coronary thrombosis* DURATION *2 hrs*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

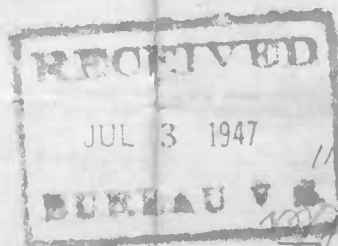
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Leonard Hays* M. D. or otherAddress *Hyattsville Md* Date signed *7-1-47*

Al Felter
Sylvan H. Hobbs
Mr. Hilley

CH 2-15
Hobbs



Sylvan
Al Felter
Ray
Houston
Hilley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05220

Reg. Dist. No. *145*

1. PLACE OF DEATH:

County *Prince George's*
City or town *Greenbelt, Maryland*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *2 days*
Hospital, institution, or street address where death occurred:
Selmon Memorial Hospital
How long in hospital or institution? *3 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Washington* County *D.C.*
City or town *Washington D.C.*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *45-9 M St S.W.*
(If rural, give LOCATION) ✓
2.(a) If veteran, name war

3.(a) FULL NAME

Agnes E. Briggsby

3.(b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Widow*
8.(b) Name of husband or wife *Thomas E.*
7. Birth date of deceased (mo., day, yr.) *January 6, 1874* 6.(c) If alive, give age *73* years
8. AGE: *73* Years Months Days If less than one day
11. Industry or business

9. Birthplace *Washington D.C.*
(Town, county, and state)
10. Usual occupation *None*
12. Name *James B. Briggsby*
13. Birthplace *England*
14. Maiden name *Josephine West*
15. Birthplace *Virginia*

16. Informant *Mrs. Loretta W. Mattingly*
Address *45-9 M St S.W.*
17. *Burial* Date thereof *June 28, 1947*
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory *Cedar Hill*
Location *Greenbelt, Maryland*

18. Funeral director *Robert A. Mattingly*
Address *131 11th St S.E. Wash. D.C.*
19. *June 25* 19*47* *James Berry*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *June 25* 19*47* at *10* a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 22nd 19*47* to *June 25th* 19*47*
and that I last saw her alive on *June 25th* 19*47*

Immediate cause of death *Cerebral hemorrhage*
Due to *Hypertensive cardiac disease*
Arteriosclerosis
Due to *Diabetes.*
Other conditions *None*
(Include pregnancy within 8 months of death)
Major findings of operations *None* Date of op.

Autopsy results *None*
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE *James B. Briggsby* M. D. or other
Address *125 11th St S.E. Wash. D.C.* Date signed *June 25, 1947*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 27 1947

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

05221

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince Georges
 City or town Clinton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 months
 Hospital, institution, or street address where death occurred:
Piscataway Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Clinton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Piscataway Road
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Howard Pinkney Hawkins Alias Richard Hawkins

3. (b) Social Security Number

578-03-1852

4. Sex male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Emma Hawkins

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: 63 Years Months Days If less than one day hrs. min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Pinkney

12. Name Henry Hawkins

13. Birthplace Maryland

14. Maiden name Emma Hawkins

15. Birthplace Maryland

16. Informant Emma Hawkins

Address Clinton, Md

17. Burial Date thereof 6 18 47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory J. B., Md

Location Tom Brook, Md.

18. Funeral director Rollins Funeral Home

Address 4339 Hunt Pl., N.E.

19. 6/15 19. 47 Mrs. Alta Davis
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1947 at 10⁴⁵ A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him..... alive on.....

Immediate cause of death..... DURATION

Cerebral

Due to Cardiovascular

renal disease

Due to.....

Other conditions Old intra cranial

hemorrhage

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy Medical Examiner M. D. or other

Address Forestville Md Date signed 6-15-47

RECEIVED

JUN 19 1947

BUREAU OF

RECEIVED
JUN 13 1947
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05223

231

1. PLACE OF DEATH:

County Prince Georges Co.,

City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

How long in above place of death?

6120 Montrose Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Geo's

City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)Street No. 6120 Montrose Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MRS. MARY A. HIGGINS

3. (b) Social Security Number

4. Sex female	5. Color or race white	6. (a) Single, married, widowed, or divorced widowed
------------------	---------------------------	---

6. (b) Name of husband or wife Joshua

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10th, 1866

8. AGE: Years 81	Months 2	Days 3	If less than one day hrs. min.
---------------------	-------------	-----------	-----------------------------------

9. Birthplace Laytonsville, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Edward H. Houck

13. Birthplace Frederick Co. Md.

14. Maiden name Ann Eliza Dwyer

15. Birthplace Montg. Co. Md.

16. Informant Mrs. Paul C. Watkins

Address 6120 Montrose Rd, Cheverly

17. Burial Date thereof June 16th, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery Laytonsville Methodist Ch.

Location Laytonsville, Md.

18. Funeral director

Address Silver Spring, Md.

19. 6/18 1947
(Date rec'd by registrar)Amanda Douney
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1947 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 13 1947 to May 19 1947

and that I last saw him alive on May 19 1947

Immediate cause of death

Coronary Atherosclerosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

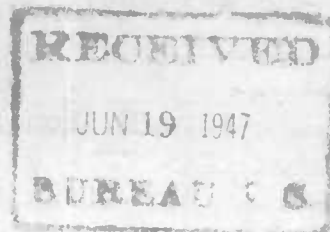
Injured at work?

23. SIGNATURE

Address 1222 W. 14th St. N. D. or other Date signed 6/14/47

Dr. Boyd The Coroner was connected
about this case.

R.R. Hellyer



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05224

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince Georges
 City or town Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mos., 26 days
 Hospital, institution, or street address where death occurred:
Glenn Dale, Sanatorium
 How long in hospital or institution? 2 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1637 R. Street, N. W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

HOFF, MIRELLA

3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>	
6. (b) Name of husband or wife <u>Herbert A. Hoff</u>			
6. (c) If alive, give age <u>33</u> years			
7. Birth date of deceased (mo., day, yr.) <u>August 20, 1923</u>			
8. AGE: <u>23</u>	Years <u>23</u>	Months <u>10</u>	Days <u>2</u> If less than one day hrs. min.
9. Birthplace <u>Florence, Italy</u> (Town, county, and state)			
10. Usual occupation <u>Housewife</u>			
11. Industry or business			
FATHER	12. Name <u>Eugenio Romanelli</u>		
	13. Birthplace <u>Florence, Italy</u>		
MOTHER	14. Maiden name <u>Enrichetta Cavini</u>		
	15. Birthplace <u>Florence, Italy</u>		

16. Informant Deceased
 Address _____

17. Burial Date thereof June 26, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington Memorial Cemetery
 Location Arlington County, Virginia

18. Funeral director Wm. Chambers Co.
 Address 1400 Algonquin St. N.W.

19. June 22, 47 Coulson S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22, 1947, at 11:20 p.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/26, 1947, to 6/22, 1947
 and that I last saw him/her alive on 6/22, 1947

Immediate cause of death pneumonia tuberculosis
 DURATION 7 mos.

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Finucane M.D.
 M. D. or other _____
 Address Glenn Dale Md. Date signed 6/22/47

RECEIVED
JUL 1 1947
BUREAU 18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05225

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George's
 City or town Cheverly
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Days 5 Hours and 30 Min.
 Hospital, institution, or street address where death occurred:
Prince George's General Hospital
 How long in hospital or institution? 6 Days 5 Hours and 30 Min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George's
 City or town Cheltenham
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

MILTON HYMILLER

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 19, 1887
 8. AGE: Years 60 Months 0 Days 24 If less than one day _____ hrs. _____ min.
 9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Salesman
 11. Industry or business _____
 12. Name Hymiller
 13. Birthplace Maryland
 14. Maiden name Elizabeth Stonecifer
 15. Birthplace Maryland

16. Informant Mrs. K. Tayman (Daughter)
 Address 233 Meadow Rd., Baltimore 25, Md.
 17. Burial Date thereof 6-14-47
 (Burial, cremation, or removal? Which?) (month) (day) (year)
 Cemetery or crematory Emil Yaskub
 Location Cedarville, Md.
 18. Funeral director Tristram Bros.
 Address Upper Marlboro, Md.
 19. 6/14 19 47 Amanda K. Hymiller
 (Date rec'd by registrar) Registrar Address

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 June 19 47 at 2:45 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 June 19 47 to 6/13 19 47
 and that I last saw him alive on 6/13 19 47
 Immediate cause of death Rocky Mountain Spotted Fever
 DURATION _____
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 Date of op. 6/14/47
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of Injury _____ Injured at work? _____
 23. SIGNATURE R. B. Jasser M. D. another
 Address Upper Marlboro, Md. Date signed 13 June 47

RECEIVED

JUN 17 1947

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince Georges
 City or town Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1224 Third St., S. W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

JANICE HYSON

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) December 5, 1946 6. (c) It alive, give age _____ years

8. AGE: Years 0 Months 0 Days 6 If less than one day 23 hrs. _____ min.

9. Birthplace Washington, D. C.
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Frank Hyson13. Birthplace Washington, D. C.14. Maiden name Catherine Leyser15. Birthplace Charleston, Maryland16. Informant Catherine HysonAddress Mother

17. Removal Date thereof June 30, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Washington DC18. Funeral director Barnes & MatthewsAddress 614-4" S.W.

19. June 28, 47 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28th 19 47 5:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23rd 19 47 to June 28th 19 47
 and that I last saw her alive on June 28th 19 47

Immediate cause of death _____

DURATION

Pulmonary Tuberculosis 12 mo.

Due to _____

(Miscary)

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistics By _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

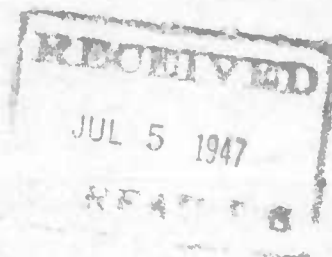
23. SIGNATURE Daniel Leo Piniscane M.D.

Glenn Dale, Md. M. D. or other _____
 Address _____ Date signed 6/28/47

MARGIN RESERVED FOR BINDING

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05227

Reg. Diat. No. 243

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 1 month, 2 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 1 month, 2 days
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D. C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1103 13th Street, N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Robert A. Johnson

3. (b) Social Security Number

579-03-7186

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife..... Ruby Oden
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1904
 8. AGE: Years 42 Months 42 Days 17 It less than one day hrs. min.

9. Birthplace..... Savage, Virginia
 (Town, county, and state)

10. Usual occupation..... Cook

11. Industry or business..... -

12. Name..... Floyd Johnson

13. Birthplace..... ? Virginia

14. Maiden name..... Annie Glazebrook

15. Birthplace..... ? Virginia

16. Informant..... Deceased

Address.....

17. Removal + Burial Date thereof 6/30/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Saved

Location..... Surry Co. Va.

18. Funeral director..... V. S. Enchly

Address..... Alexandria, Virginia

19. June 30, 47 Rowland S. Philips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 6/30 1947, at 1:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/27 1947, to 6/30 1947, and that I last saw him alive on 6/30 1947.

Immediate cause of death..... Pulmonary Tuberculosis DURATION 1 year

Due to.....

Due to.....

Other conditions..... Tuberculous meningitis 9 days

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Pinucane M.D.

Address..... Glenn Dale, Md. Date signed 6/30/47

RECEIVED

JUL 5 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05228

1. PLACE OF DEATH:

County..... Prince George's
 City or town..... Greenbelt
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 hrs. 40 min.
 Hospital, institution, or street address where death occurred:
Engineer Leland Memorial Hospital
 How long in hospital or institution? 11 hrs. 40 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... md County..... Prince George's
 City or town..... Greenbelt
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 57 Bridge Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Thomas Jefferson Johnson

3. (b) Social Security Number

none

4. Sex..... male
 5. Color or race..... white
 6.(a) Single, married, widowed, or divorced..... widowed

6.(b) Name of husband or wife..... Martha Jane Johnson
 6.(c) If alive, give age..... one negro years

7. Birth date of deceased (mo., day, yr.)..... Aug. 1, 1872

8. AGE: Years..... 74 Months..... 10 Days..... 23 If less than one day..... hrs. min.

9. Birthplace..... Baltimore, md
 (Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business..... marine engineer

12. Name..... Thomas Jefferson Johnson

13. Birthplace..... Baltimore, md

14. Maiden name..... Josephine Crispford

15. Birthplace..... Baltimore, md

16. Informant..... Chas. E. Howard Johnson (son)

Address..... 57 Bridge Rd. Greenbelt, md

17. Burial..... Date thereof..... June 26, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Cedar Hill Cem.

Location.....

18. Funeral director..... Chas. P. Towell

Address..... 2727 Edmondson Ave.

19. June 25, 1947..... A. H. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 24 1947 at 1:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19....., to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death..... acute congestive heart failure

Due to..... cardiac atherosclerotic disease

Due to.....

Other conditions..... fracture of 8th and 10th ribs
right side
 (Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of..... 6-23-47

Where did injury occur..... Greenbelt (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... home

Means of injury..... fell down steps Injured at work? no

23. SIGNATURE..... Asst. J. C. [illegible] M. D. or other

Address..... Forestville Md Date signed..... 6-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05229

Reg. Diat. No. 231

1. PLACE OF DEATH:

County Prince George
 City or town Chesley
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Prince George General Hosp.
 How long in hospital or institution? 11 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Geo.
 City or town Mt. Rainier
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4212 - 28th St., Apt #3
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Agnes V. Kinsella

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) March 28, 1870
 8. AGE: Years 47 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace New Orleans, Louisiana
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Wm. J. Phillips
 13. Birthplace La.
 MOTHER 14. Maiden name Unknown
 15. Birthplace

16. Informant Mrs. Cecelia K. Kulikowski
 Address 4212 - 28th St. Mt. Rainier, N.H. 1673

17. Burial Date thereof July 1, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Metairie Cemetery
 Location New Orleans, Louisiana

18. Funeral director Wm. J. Haller
 Address 3200 - A St. Mt. Rainier, Md.

19. 7/1 1947 Amanda Dooney
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 June 1947 at 6 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 May 1947, to 30 June 1947, and that I last saw her alive on 29 June 1947.

Immediate cause of death acute congestive heart failure

Due to Coronary arteriosclerosis Heart Disease

Due to.....

Other conditions Chronic cholecystitis 12 years
with cholelithiasis
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Samuel J. N. Sugar M.D. or other

Address Mt. Rainier, Md. Date signed 30 June 47

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JUL 2 1947

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05230

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
 County Prince Georges
 City or town Mt. Rainier
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Mt. Rainier
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4605-30-5A
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME
LAMB, EDITH

3. (b) Social Security Number

4. Sex Female 5. Color or race Wh 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Albert L. Lamb

7. Birth date of deceased (mo., day, yr.) July 18, 1866 8. (c) If alive, give age _____ years

8. AGE: Years 80 Months 10 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Hartford, Conn.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER 12. Name Samuel C. Hurlbut

13. Birthplace Hartford, Conn.

14. Maiden name Emily Louise Carey

15. Birthplace Hartford, Conn.

16. Informant Dorothy O'Brien (daughter)

Address 4605-30-5A, Mt. Rainier

17. (Burial, cremation, or removal) Which? Transportation Date thereof June 3, 1947
 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Hartford Connecticut

18. Funeral director F. Gucci's sons

Address Hyattsville Md.

19. June 3 1947 Wm. Joe Severe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1947 at 2:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1947 to June 3 1947

and that I last saw him alive on June 2 1947

Immediate cause of death Heart disease, arteriosclerosis

Due to _____ DURATION 2 yrs. +

Due to _____

Due to _____

Other conditions Prolapsus uteri 10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wm. M. Gassgreen M.D. M. D. or other

Address 2503 Queens Chapel Rd. Date signed 6-3-47

Mt. Rainier, Md.

CERTIFICATE OF DEATH

RECEIVED

JUN 6 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH: Prince George
County Cheverly
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3013 Crest Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Bertha Latitte

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
Oct. 21, 1866 ULYSSES P.
B.(b) Name of husband or wife 17 July 1881 6.(c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) DECEASED (UNKNOWN) 1882

8. AGE: Years 65 Months 11 Days 27 If less than one day
hrs. min.

9. Birthplace Baton Rouge, Louisiana
(Town, county, and state)

10. Usual occupation Govt. Clerk

11. Industry or business GOVERNMENT PRINTING OFFICE

12. Name Joseph BLANCHARD

13. Birthplace LA.

14. Maiden name Celestine Letene

15. Birthplace LA.

16. Informant LOUISE SKINNER

Address 3013 - Crest Ave. Cheverly

17. Burial Date thereof June 21, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Not Olivet Cemetery

Location Washington D.C.

18. Funeral director Thomas B. Haulon

Address 641 - 2nd St NE

19. June 21 19 47 Miss Jan Severe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 19 47 at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 19 47 to June 21 19 47

and that I last saw her alive on June 20 19 47

Immediate cause of death Hypertensive Heart Disease DURATION 10 yrs.

Due to

Due to

Other conditions Fibrillation of Heart IMO.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles C. Hageage M.D. M. D. or other H. Rainier, M.D.
Address June 21/47 Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 25 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05237

231

1. PLACE OF DEATH:

County..... Prince George's

City or town..... Cheverly, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days and 4 1/2 hours

Hospital, institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution? 12 days and 4 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Prince George's

City or town..... Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

BIRDIE LEDERER

3.(b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

February 6, 1877

8. AGE:

Years

70

Months

4

Days

22

If less than one day

hrs.

min.

9. Birthplace..... Prince George's County, Md.

(Town, county, and state)

10. Usual occupation.....

Retired Government clerk

11. Industry or business

FATHER

12. Name

Philip B. Lederer

13. Birthplace

Maryland

MOTHER

14. Maiden name

Anne Jones

15. Birthplace

Maryland

16. Informant..... Mrs. Harry Sweeney (Sister)

Address..... Upper Marlboro, Md.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof..... June 28, 1947

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

300-4th St. N.E.

6/28 19 47

(Date rec'd by registrar)

Amanda Downey

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 19 47 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 2 19 47 to June 28 19 47

and that I last saw him alive on June 28 19 47

Immediate cause of death

DURATION

Carcinoma of Larynx - with metastases to lungs 6 months

Due to

Due to

Other conditions

Secondary anemia 6 months

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

James G. Surcen M.D.

M. D. or other

Address

Upper Marlboro, Md

Date signed 6-28-47

RECEIVED

JUL 2 1947

BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05232

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Pro Geo CoCity or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pro Geo CoCity or town Brentwood Md
(If outside city or town limits, write RURAL and give nearest town)Street No. 3715 Carnum St

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Margaret Leonhardt

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) ? 18638. AGE: Years 84 Months ? Days ? If less than one day ? hrs. ? min. ?9. Birthplace Md.
(Town, county and state)10. Usual occupation at home11. Industry or business Retired Leonhardt12. Name Retired Leonhardt13. Birthplace Md14. Maiden name Carnum15. Birthplace Va16. Informant Edna M LinkAddress 3715 Carnum St Brentwood17. Burial Date thereof 6/21/47
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory EvergreenLocation Bladensburg Md18. Funeral director F. Gueck's SonsAddress Hyattsville Md.June 21 1947 James Sevey

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1947 at ? M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from several years to June 19 1947and that I last saw him alive on 2 AM June 17 1947

Immediate cause of death

Chronic myocarditisDue to SenilityDue to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? —23. SIGNATURE W. Allen Giffith M. D. or otherAddress Berwyn Md Date signed June 20, 1947

MARGIN RESERVED FOR BINDING

VS. A15

9-45-15W

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 24 1907

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 106

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County **PRINCE GEORGES**
City or town **RIVERDALE**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **bleed on arrival**
Hospital, institution, or street address where death occurred:
Telord Memorial Hospital
How long in hospital or institution? **no**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State **Maryland** County **Howard**
City or town **Ellicott City**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **R.F.D. #2**
(If rural, give LOCATION)
2.(a) If veteran, name war **no**

3. (a) FULL NAME

HARRISON LAWRENCE LEWIS

3. (b) Social Security Number

4. Sex **male** 5. Color or race **colored** 6.(a) Single, married, widowed, or divorced **married**
6.(b) Name of husband or wife **Lottie May Lewis**
7. Birth date of deceased (mo., day, yr.) **Dec 5, 1919**
8. AGE: Years **27** Months **6** Days **20** If less than one day **hrs. min.**

9. Birthplace **Sikesville Md**
(Town, county, and state)

10. Usual occupation **Laborer**
Farm

11. Industry or business **WILLIAM LEWIS**

12. Name **Maryland**

13. Birthplace **FLORENCE TAYLOR**

14. Maiden name **Maryland**

15. Birthplace **Lottie May Lewis**

16. Informant **Waterloo, Md**

17. Burial (Burial, cremation, or removal. Which?) **Burial** Date thereof **July 3, 1947**
(month) (day) (year)

Cemetery or crematory **St. Stephens Cem.**

Location **Ellicott City, Md.**

18. Funeral director **HIGENBOTHAM CO.** **El 110**

Address **EL LICOTT CITY MARYLAND**

19. **July 47** **James Evans** Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **June 30, 1947** 19 **30** at **1:30 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 **30** to 19 **30** and that I last saw h. **alive on** 19 **30**

Immediate cause of death **Hemorrhage and shock**
Due to **Laceration of femoral artery**
Due to **gun shot wound of right groin**
Other conditions **no**

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations **Date of op.**

Autopsy results **PHYSICIAN: Please underline the cause to which death should be charged statistically.**

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide **Homicide** Date of **6-30-47**
Where did injury occur? **Waterloo Howard Md**
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) **no**
Means of injury **shot with shot gun** Injured while **working**
Report, Medical Examiner

23. SIGNATURE **James Evans** M.D. or other **no**
Address **Forestville Md** Date signed **6-30-47**

MARGIN RESERVED FOR BINDING

I

VS A15 7-22-47

REPLACEMENT CERTIFICATE::SEE LL:RUSSH::

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

05238

RECEIVED
JUL 28 1947
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

05233

1. PLACE OF DEATH:

County Prince George
 City or town Chesley
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mo 9 da
 Hospital, institution, or street address where death occurred:
Prince George General Hospital
 How long in hospital or institution? 2 mo 9 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
 City or town Chesley
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 204 72nd Place N.E.
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

Carol Ann Sumford

3. (b) Social Security Number

4. Sex female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 9, 1945
 6. (c) If alive, give age _____ years

8. AGE: Years 2 Months 0 Days 12
 If less than one day _____ hrs. _____ min.

9. Birthplace D.C.
 (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Raymond J. Sumford
 13. Birthplace Ind.

MOTHER 14. Maiden name Arrie M. N. Von
 15. Birthplace Tennessee

16. Informant Father
 Address

17. Burial Date thereof 6/24/47
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Washington Natl
 Location

18. Funeral director W. W. Chambers &
 Address 577-11st St

19. 6/21 19 47 Amanda Conway
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 June 1947 19 47 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 June 19 47 to June 21 19 47
 and that I last saw him alive on 6/21 19 47

Immediate cause of death Uremia

Due to hypoid Septicemia

Due to septicemia

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results Septicemia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thomas A. O'Leary M. D. or other

Address College Park, Md Date signed 6/21/47

RECEIVED
JUN 25 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05234

48a

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George's
 City or town Cheverly
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:
Prince George's General Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's
 City or town Hyattsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 3906 Kennedy St.
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

MARIE E. MARSHALL

3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Edgar P. Marshall

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 2, 1895

8. AGE: Years 52 Months 3 Days 0 If less than one day _____ hrs. _____ min.

9. Birthplace Geneseo, New York
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Joseph S. Moore

13. Birthplace New York

14. Maiden name Isabelle McCaughey

15. Birthplace Ireland

16. Informant Mr. Edgar P. Marshall

Address 3906-Kennedy St., Hyattsville, Md.

17. Burial Date thereof June 5, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Francis

Location Colman Manor, Md.

18. Funeral director McG. H. Hines Co.

Address 2901-14th St. N.W., Washington, D.C.

19. 6/2 19 47 Amanda Dorey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 19 47, at 7:46 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 2 19 46 to June 2 19 47

and that I last saw her alive on June 2 19 47

Immediate cause of death _____

Carcinoma of Cervix DURATION 1 year.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

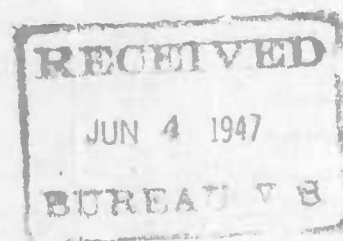
Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Alfred G. H. M. D. or other

Address Hyattsville, Md. Date signed 6-2-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change
of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05235

FILE NO. G 110 JUN 24 1947 CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George

City or town Chesapeake

How long in above place of death? 5 hrs 20 min

Hospital, institution, or street address where death occurred
Prince George General Hosp

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Hyattsville

Street No. 1702 - Englewood Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Joseph Marucci

3.(b) Social Security Number

4. Sex male

5. Color or race white

6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Margaret Marucci

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1876

8. AGE: 70 Years 64 Months Days It less than one day

9. Birthplace Italy

10. Usual occupation Barber

11. Industry or business

12. Name Antonio Marucci

13. Birthplace Italy

14. Maiden name Mary

15. Birthplace Italy

18. Informant Hospital Record

Address

17. Burial Date thereof 6/17/47

(Burial, cremation, or removal Which?) (month) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Washington D.C.

18. Funeral director J. W. Lee Sons Co

Address 308 - 4th St. N.E.

19. 6/14 19 47 Washington D.C.

(Date rec'd by registrar) Amanda W. ...

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 19 47 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on 19...

Immediate cause of death

Intra cranial hemorrhage

Due to Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Deputy Medical Examiner

23. SIGNATURE Forestville Md.

Address Forestville Md. Date signed 6-14-47

RECEIVED

JUN 17 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05236

231

1. PLACE OF DEATH:

County Prince George's
 City or town Cheverly
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 hrs - 16 min
 Hospital, institution, or street address where death occurred:
Prince Georges Hosp.
 How long in hospital or institution? 2 hrs - 16 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Prince George
 City or town Lacrosse
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. RFD #2 - Box 188
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Ms Mahon, Gertrude

3. (b) Social Security Number

4. Sex Female 5. Color or race W 6.(a) Single, married, widowed, or divorced 67

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1879

8. AGE: Years 67 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Washington, DC
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name Thomas Harrison

13. Birthplace DC

14. Maiden name Mary F German

15. Birthplace Mass

16. Informant Mrs Mildred Lanning

Address Lacrosse Md. Box 188

17. Burial Date thereof June 7, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Bladensburg Rd. N.E. Wash. DC

18. Funeral director Wm. J. Malley

Address 3200 - R.D. Ave. Mt. Rainier, Md.

19. 6/6 19 47 Amanda Deane
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 19 47 at 11¹⁵ P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-2-47 19 47 to 6-2 19 47

and that I last saw him/her alive on 6-2-47 19 47

Immediate cause of death.....

Hemorrhage
Gastric

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results Dissecting Arteries in
 PHYSICIAN: Please underline the cause to which death should be charged statistically. Dissecting Aorta

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Floyd W. Hughes MD
 M. D. or other

Address Prince George General Date signed 6-3-47

5521.02.300

RECEIVED

JUN 9 1947

BUREAU V S

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JUN 9 1947
BUREAU V S
JUN 9 1947
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05239 231

1. PLACE OF DEATH:
County Prince George's
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One day and 5 1/2 hours
Hospital, institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution? One day and 5 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Hillside, Washington 19 (D.C.)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1205-61st. Avenue
(If rural, give LOCATION) ✓

3. (a) FULL NAME

KATHERINE MEYERS

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife _____
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) January 17, 1871
8. AGE: Years 76 Months 3 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business _____
12. Name Jacob Essig
13. Birthplace Germany
14. Maiden name Elizabeth Pieffer
15. Birthplace Pennsylvania

16. Informant Mrs. Barry (Daughter)
Address 2133 Eye St., N.W., Washington,
17. Removal Date thereof June 20-1947
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory _____
Location Washington D.C.
Sh. M. Chambers Co
18. Funeral director 517-11th ST. SE WASH. D.C
Address _____
19. June 20 19 47 Circumstances
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20, 19 47, at 5:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 19 47 to June 20 19 47 and that I last saw him alive on June 20 19 47

Immediate cause of death Cerebral Hemorrhage DURATION 2 days

Due to Hypertension cardiac-vascular renal disease 15 years

Due to _____
Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William Brainerd M. D. or other _____
Address Capitol Hill Date signed 6/20/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 25 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05240

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges
 City or town Cheney
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 hrs. 20 min
 Hospital, institution, or street address where death occurred:
Prince Georges General Hosp
 How long in hospital or institution? 3 hrs 20 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pennsylvania County
 City or town Philadelphia
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2141 Mt Vernon Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Joseph Mignogna

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Separated

6. (b) Name of husband or wife -

7. Birth date of deceased (mo., day, yr.) May 24, 1916 6. (c) If alive, give age - years

8. AGE: Years 31 Months Days If less than one day hrs. min.

9. Birthplace Philadelphia Pa.
 (Town, county, and state)

10. Usual occupation night auto race driver

11. Industry or business

12. Name Pasquale Mignogna
 13. Birthplace Italy

14. Maiden name Concetta Crecito
 15. Birthplace Italy

16. Informant Pasquale Mignogna
 Address Philadelphia Pa
transportation Date thereof June 21, 1947
 (Marriage, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Philadelphia
Penna.

Location

18. Funeral director F. Buschi song
 Address Wyalitville Md.

19. 6/21 19 47 Amenda Deany
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1947, at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Hemorrhage and shock
 Due to Crushed skull
 Due to

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of 6-20-47
 Where did injury occur? Towson (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Speedway
 Means of injury night auto race Injured at work no

23. SIGNATURE James D. Long M. D. or other
 Address Forestville Md Date signed 6-21-47

RECORDED
JUN 25 1957
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05241

Reg. Dist. No. 243.

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 mos., 24 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution? 10 mos., 24 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D. C. County..... Washing-
 City or town..... 1904 Stanton Terrace, S. E. ton, D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1904 Stanton Terrace, S. E.
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

JAMES MINOR

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Annie Minor

6. (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) November 2, 1905

8. AGE: Years 41 Months 7 Days 15 If less than one day
 hrs. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business

12. Name Edward Minor

13. Birthplace Washington, D. C.

14. Maiden name Grace Wilson

15. Birthplace Washington, D. C.

16. Informant Deceased

Address

17. Burial, cremation, or removal. Which? Removal Date thereof 6/17/47
(month) (day) (year)

Cemetery or crematory

Location Washington, D.C.

18. Funeral director R. M. Horton Co.

Address 1322 U. St. N.W.

19. June 17, 1947 Rowlands, Philip Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 17 1947 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 JULY 23 1946 to JUNE 17 1947
 and that I last saw him alive on JUNE 17 1947

Immediate cause of death Pulmonary Tuberculosis
 DURATION 2 yr. 4 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

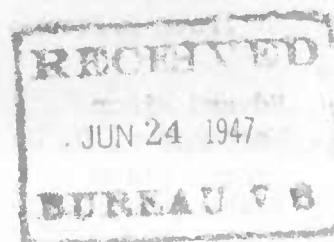
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinicane MD

Address Glenn Dale, Md. Date signed 6-17-47



12-2-47
R-11
11-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

05242

245

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Prince Georges Co

City or town..... Riverdale Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Prince Geo Co

City or town..... Riverdale Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No..... 4606 Queensbury Road
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Virginia Mollohan

3. (b) Social Security Number

--

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife..... Samuel Mollohan

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

May 28, 1857

8. AGE:

Years

Months

Days

If less than one day

90

hrs.

min.

9. Birthplace.....

West Virginia
(Town, county, and state)

10. Usual occupation.....

at home

11. Industry or business

FATHER

12. Name.....

Thomas L. Mc Gray

13. Birthplace.....

West Virginia

MOTHER

14. Maiden name.....

Jane Stone

15. Birthplace.....

West Virginia

16. Informant.....

Mrs Altha Jardine

Address.....

Riverdale Maryland

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof.....

June 19, 1947
(month) (day) (year)

Cemetery or crematory.....

Congressional

Location.....

Washington D. C.

18. Funeral director.....

F. Gasch's Sons

Address.....

Hyattsville Maryland.

19.

June 18, 1947
(Date rec'd by registrar)Mrs. J. S. Severs
District Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 17, 1947 .. 19. 6 at 6AM .. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

May 11, 1947 to June 17, 1947

and that I last saw her alive on June 16, 1947

Immediate cause of death.....

Comm. Fractured Left Femur
Comp. Fractured Left Femur
Due to Fracture of Left Femur

DURATION

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of June 17, 1947

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... Home (8/20/47) (State)

Manner of injury..... Fell on floor Injured at work?

23. SIGNATURE.....

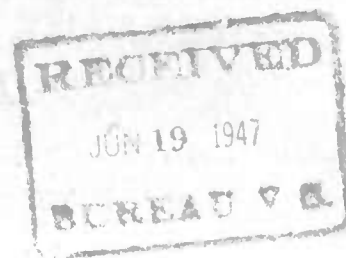
C. DeWitt

M. D. or other

Address.....

Hyattsville Md

Date signed..... 6/18/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05243

Reg. Dist. No. *415*

1. PLACE OF DEATH:

County *Prince Geo. Co*
 City or town *Hyattsville*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *3 yrs*
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *md* County *Pr. Geo. Co*
 City or town *Hyattsville*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *5719-43rd Ave. Garfield Court*
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lucien Joseph Moret

3. (b) Social Security Number

4. Sex *m* 5. Color or race *w* 6. (a) Single, married, widowed, or divorced *married*6. (b) Name of husband or wife *Lillian Moret*7. Birth date of deceased (mo., day, yr.) *may 25 - 1892* 6. (c) If alive, give age _____ years8. AGE: Years *55* Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace *New Orleans -*
(Town, county, and state)10. Usual occupation *Corporal Public Accountant*

11. Industry or business

12. Name *Edward Moret*13. Birthplace *France*14. Maiden name *Laurence Rouen*15. Birthplace *New Orleans*16. Informant *Lucien J. Moret Jr.*Address *5703-43rd Ave Hyattsville*17. (Burial, cremation, or removal. Which?) *Buried* Date thereof *as of 4/7*Cemetery or crematory *Metairie Cemetery*Location *New Orleans, La*18. Funeral director *WW Chauhan Co*Address *Riverdale - md*19. *June 1* 19 *47* *mm* *Joe Severo*

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *June 1* 19 *47* at *10 A* M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *May 22* 19 *47* to *June 1* 19 *47* and that I last saw him alive on *May 29* 19 *47*Immediate cause of death *Coronary sclerosis* DURATION *4 yrs*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Lucien and Harry*Address *Hyattsville, Md.* M. D. or otherDate signed *7-7-47*

RECEIVED

JUN 3 1947

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

05244

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County... Prince George
 City or town... Suitland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 mo.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Prince Geo.
 City or town... Suitland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4679 Homer Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

Nicholas Murphy

3. (b) Social Security Number

none

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Erida Murphy

7. Birth date of deceased (mo., day, yr.)

May 20, 1877

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

70

hrs.

min.

9. Birthplace

New York City N.Y.

(Town, county, and state)

10. Usual occupation

Retired Chiropractor

11. Industry or business

FATHER

12. Name

Thomas Murphy

13. Birthplace

Ireland

MOTHER

14. Maiden name

Mary Ellen Mac Miller

15. Birthplace

Port Chester, N.Y.

16. Informant

Mrs. Loretta Diordano

Address

4679 Homer Ave. Suitland Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

June 16, 1947
(month) (day) (year)

Cemetery or crematory

Evergreen Cemetery

Location

New York City

18. Funeral director

W. W. Chambers Co.

Address

517 11th St. S. E.

19.

Date rec'd by registrar

June 14, 1947

Carrie F. Campbell

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1947, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 11, 1947, to June 13, 1947

and that I last saw him alive on June 13, 1947

Immediate cause of death

DURATION

Myocarditis
Death prostration

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Andrew Anders

M. D. or other

Address

4679 Homer Ave.

Date signed 6/13/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 16 1947
BUREAU 58

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05245
243

1. PLACE OF DEATH:

County..... Prince Georges
City or town..... Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 20 days
Hospital, institution, or street address where death occurred:
..... Glenn Dale Sanatorium
How long in hospital or institution?..... 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D. C.
County.....
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1230 Irving St., N. W.
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME

LORENZO S. NEALE

3. (b) Social Security Number

4. Sex..... Male
5. Color or race..... Colored
6. (a) Single, married, widowed, or divorced..... Single

6. (b) Name of husband or wife.....
6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... June 6, 1917
8. AGE: Years..... 30 Months..... 0 Days..... 20 If less than one day..... hrs. min.

9. Birthplace..... Washington, D. C.
(Town, county, and state)

10. Usual occupation..... Musician

11. Industry or business.....

12. Name..... Alfred Neale

13. Birthplace..... ?

14. Maiden name..... Lillian Prather

15. Birthplace..... ?

16. Informant..... Deceased

Address.....

17. removal Date thereof June 27, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... Washington D.C.

18. Funeral director..... Geo. W. Lewis & Co.

Address 1225 11th St., N.W., Wash., D.C.

19. 6-27-47 Registrar
(Date rec'd by registrar) 19. Rowland S. Phillips

MEDICAL CERTIFICATION

20. DATE OF DEATH..... JUNE 26 1947 at 10⁰⁰ A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 5 1947 to JUNE 26 1947 and that I last saw him alive on JUNE 26 1947

Immediate cause of death..... Pulmonary Tuberculosis
DURATION 3 yr. 9 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Pinucane M.D.
M. D. or other

Address..... Glenn Dale, Md., Date signed 6-26-47

RECEIVED

JUL 5 1947

BUREAU V B

PLEASE WRITE PLAINLY. WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05246 231

1. PLACE OF DEATH:

County Prince George'sCity or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)Street No. 4029 34th Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Frank C. Neuman

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Lilia Neuman

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 17, 1888

8. AGE:

Years

Months

Days

If less than one day

58

..... hrs. min.

9. Birthplace Cleveland, Ohio
(Town, county, and state)10. Usual occupation Gas Station Attendant

11. Industry or business

12. Name Frank H. Neuman13. Birthplace N. Y.14. Maiden name Mary Hunt15. Birthplace Unknown18. Informant Hospital Records

Address

17. Burial Date thereof July 1, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort Lincoln CemeteryLocation 3201-Bladenburg Rd. Colmar Manor, Md.18. Funeral director William J. NalleyAddress 3200-R.E. Ave. Mt. Rainier, Md.19. 7/1 47 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 19 47 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death Cerebral compression

DURATION

Due to Intra cranial hemorrhageDue to Fracture of the base of the skullOther conditions Cardiovascular renal dissection

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results Given above

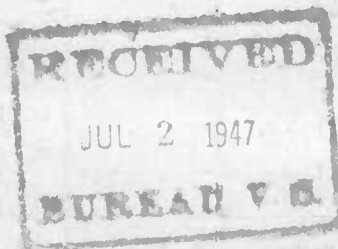
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/18/47Where did injury occur? Forestburg, Md. (City or town) (State)Injured at home, farm, industry, public place (where?) StreetMeans of Injury Fell from a car Injured at work? no

Deputy Medical Examiner

23. SIGNATURE James D. Boyd M. D. orAddress Forestville, Md. Date signed 6/28/47



Chlor
Julia M. Harrison
Wichita Falls, Texas
July 17, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH: Prince George
 County..... 5910 Chillum Gate Rd.
 City or town..... Chillum, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Md. County..... Prince George
 City or town..... Chillum, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 5910 Chillum Gate Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Freeman William Opdyke

3. (b) Social Security Number

4. Sex..... Male
 5. Color or race..... W
 6. (a) Single, married, widowed, or divorced..... Married

8. (b) Name of husband or wife..... Bessie L.

7. Birth date of deceased (mo., day, yr.)..... Nov 27- 1879
 8. (c) If alive, give age..... years

8. AGE: Years..... 67 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Dover, N. J.
(Town, county, and state)

10. Usual occupation..... Gen Acct't Office
U.S. Gov

11. Industry or business

12. Name..... Samuel Opdyke13. Birthplace..... N. J.14. Maiden name..... Ellen Snyder15. Birthplace..... N. J.16. Informant..... Mrs Bessie OpdykeAddress..... 5910 Chillum Gate Rd.

17. removal Date thereof..... June 19, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Pleasant Cem.Location..... Newark, N. J.18. Funeral director..... The S. W. Hines Co.Address..... 2901-14 St N W

19. June 19, 1947 Mrs. Jas. Severel
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 19, 1947 at 2:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 4, 1947 to June 19, 1947
 and that I last saw him alive on June 18, 1947

Immediate cause of death..... Pulmonary edemaDue to..... Myocardial InfarctionDue to..... Myocardial Infarction

Other conditions.....

(Include pregnancy within 3 months of death)
 Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Robert R. Hines M. D. or otherAddress..... 1227 Monmouth Date signed..... 6/19/47

CERTIFICATE OF DEATH

RECEIVED
JUN 20 1947
BUREAU 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05248

Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince Georges
 City or town Washington 20, DC
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 yrs.
 Hospital, institution, or street address where death occurred:
1726 Owens Rd., S.E.
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Georges
 City or town Washington 20, DC
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1726 Owens Rd., S.E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

HERMAN OWENS

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife Hannah Owens

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 28, 1882

8. AGE: Years 65 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Prince Georges Co. - Maryland
(Town, county and state)10. Usual occupation Truck farmer

11. Industry or business

12. Name Grafton Owens13. Birthplace Maryland14. Maiden name Maria Ferguson15. Birthplace Washington, DC16. Informant Mrs. Walter TurnerAddress Washington 20 DC (sister)17. Burial (Burial, cremation, or removal) (Which?) Burial Date thereof June 13, 1947
(month) (day) (year)Cemetery or crematory St. Barnabas CemeteryLocation Oxon Hill Ind.18. Funeral director Arthur E. Simmons, Jr.Address 7007 Nichols Ave S.E.
Washington, DCJune 15, 1947 Frederic D. Baird
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1947, at 7:30 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1947 to June 8 1947and that I last saw him alive on June 8 1947Immediate cause of death acute myocardial DURATION 2 days
DecompensationDue to Chronic arteriosclerosis unknown
myocardialDue to General arteriosclerosisOther conditions Atrophic Pericarditis unknown
of Liver

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 20

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frederic D. Baird M. D. Frederic D. BairdAddress Washington 18 DC Date signed June 15, 1947

RECEIVED

JUN 19 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

48a

05249

mf5

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Prince George's
 City or town Riversdale, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 52 days 4 yrs.
 Hospital, institution, or street address where death occurred:
Leland Memorial Hosp.
 How long in hospital or institution? 52 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's
 City or town Riversdale
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6507 Well Parkway
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Jacqueline Leigh Parker

3. (b) Social Security Number

4. Sex Female 5. Color or race W 6.(a) Single, married, widowed, or divorced widow
 6.(b) Name of husband or wife Arthur James Parker 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) 11-19-1900
 8. AGE: Years 46 Months 6 Days 22 If less than one day
 hrs. min.

9. Birthplace Oklahoma
 (Town, county, and state)
 10. Usual occupation Shoe Retail Worker
 11. Industry or business
 12. Name Charles L. Allen
 13. Birthplace
 14. Maiden name Ornah Cadlock
 15. Birthplace

16. Informant Mr. C. W. Walter
 Address 6315 Rhode Island Ave. Riverdale
 17. Burial Date thereof 6/13/47
 (Burial, cremation, or removal Which?) (month) (day) (year)
 Cemetery or crematory Evergreen
 Location Bladenburg, Md.
 18. Funeral director F. Hasch's Sons
 Address Hyattsville, Md.
 19. 6/13 1947 Amanda Deuney
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1947 at 4:45 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-18 1947 to 6-10 1947
 and that I last saw h. ER alive on 6-7 1947

Immediate cause of death DURATION
Severe debilitation
 Due to Carcinoma of Cervix
 Due to Extensive metastases
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Lowell H. Wilkerson MD M. D. or other
 Address 4404 Greenbury Rd Date signed 6-10-47

RECEIVED

JUN 16 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46d

05250

CERTIFICATE OF DEATH

Reg. Dist. No. 243

I. PLACE OF DEATH:

County P. Geo.City or town Bowie, Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 35 yrs

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

Helen Christine Porter

3. (b) Social Security Number

4. Sex Female5. Color or race Colored6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband Clinton Porter6. (c) If alive, give age Dead years7. Birth date of deceased (mo., day, yr.) Nov. 4th 18958. AGE: Years 51 Months 7 Days 6 If less than one day _____ hrs. _____ min.9. Birthplace Upper Marlboro, Md
(Town, county, and state)10. Usual occupation House work11. Industry or business None12. Name William Quander13. Birthplace Towson, P. Geo. Md14. Maiden name Bessie Bonds15. Birthplace Croome, Md16. Informant Alic E. HallAddress Bowie, Md17. Burial Date thereof June 14, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Union CemeteryLocation Upper Marlboro, Md18. Funeral director B. B. VinsonAddress Annapolis Md19. June 13, 1947 Two J. W. Gierling
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County P. Geo.City or town Bowie, Md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1947 at 7:35 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1947 to June 10 1947and that I last saw him alive on June 10 1947Immediate cause of death Carcinoma of the Breast DURATION _____

Due to _____

Due to _____

Other conditions Colostomy P.D. andOld arrested Pulmonary P.D.

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE W. Quander, M.D.
M. D. or other _____Address Bowie Md Date signed 6/10/47

RECEIVED

JUN 18 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47c

05251

Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince George

City or town Allentown, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Allentown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6202-Allentown Rd., S.E.

(If rural, give LOCATION)

2.(a) Is veteran, name war

3. (a) FULL NAME

JOHN T. REDD

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Hester E. Redd

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10th 1871

8. AGE: Years Months Days If less than one day

75

8

25

hrs. min.

9. Birthplace Camp Springs, Maryland

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Navy Yard

12. Name Daniel T. Redd

13. Birthplace Md.

14. Maiden name Eleanor C. Hutchinson

15. Birthplace Md.

16. Informant Hester E. Redd

Address 6202-Allentown Rd., S.E. Wash. 20 DC

17. Buried Date thereof June 9, 1947

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Smithland, Md.

18. Funeral director Arthur E. Simpson

Address 2007- Nichols Ave S.E.

19. June 5 19 47 Howard J. Beach

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5th 19 47 at 3:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 28th 19 47 to May 31st 19 47

and that I last saw him alive on May 31st 19 47

Immediate cause of death Virus pneumonia

DURATION

2 mos.

Due to Probable Bronchio-genic carcinoma

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? None

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of Injury None Injured at work?

23. SIGNATURE Howard J. Beach

Address 1252 6th Street, S.W. M.D. or other

Date signed 6/5/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 12 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05252

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince Georges
 City or town Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr., 8 mos., 1 day
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 1 yr., 8 mos., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2408 N. Street, N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

CLARENCE RHODES

3. (b) Social Security Number

578-03-7645

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Mary Rhodes (deceased)6.(c) If alive, give age 45 years7. Birth date of deceased (mo., day, yr.) July 8, 1904

8. AGE: Years 42 Months 42 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D. C.
(Town, county, and state)10. Usual occupation Laborer11. Industry or business D. C. Government12. Name Leonard Naylor13. Birthplace ?14. Maiden name Lucy Rhodes15. Birthplace Washington, D. C.16. Informant Deceased

Address _____

17. Removal Date thereof June 20 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Rockville Md18. Funeral director Robert L SnowdenAddress 246 N. Washington St (Rockville Md)19. June 19, 47 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH JUNE 19 1947 at 8:30 p m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-17 45 to JUNE 19 47
 and that I last saw him alive on JUNE 19 47

Immediate cause of death PULMONARY TUBERCULOSIS DURATION 3 yrs 3 mo

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

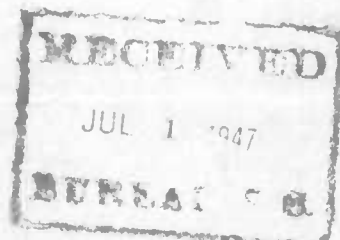
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinecare MD M. D. or other _____Address Glenn Dale Md Date signed 6/19/47



M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05253

 CB
 Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 1 mo., 9 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution?..... 1 mo., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... D. C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1719 Kalorama Rd., N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

IRENE ROBINSON

3. (b) Social Security Number

Lost it.

4. Sex..... Female
 5. Color or race..... Colored
 6. (a) Single, married, widowed, or divorced..... Married

6. (b) Name of husband or wife..... Andrew Robinson

6. (c) If alive, give age..... 25 years
 7. Birth date of deceased (mo., day, yr.)..... November 10, 1927

8. AGE: Years..... 19 Months..... 6 Days..... 25 If less than one day..... hrs. min.

9. Birthplace..... Winston Salem, North Carolina
 (Town, county, and state)

10. Usual occupation..... Maid - Unemployed

11. Industry or business..... Ambassador Hotel

FATHER
 12. Name..... Colonel Glenn
 13. Birthplace..... Winston Salem, North Carolina

MOTHER
 14. Maiden name..... Juanita Guthell
 15. Birthplace..... Dave Co., North Carolina

16. Informant..... Deceased
 Address.....

17. Removal..... Date thereof..... June 5th 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....
 Location..... Wash. D.C.

18. Funeral director..... R.N. - Martins Co.
 Address..... 1322 1/2 St NW

19. June 5 1947 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 4th 1947 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 1947 to June 4th 1947 and that I last saw her alive on June 4th 1947

Immediate cause of death..... Pulmonary Tuberculosis
 DURATION..... 6 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Finucane MD
 M. D. or other

Address..... Glenn Dale, Md. Date signed..... 6/4/47

RECEIVED
JUN 18 1947
BUREAU V S.

1345 - 100 - 100
WV-12 - 100 - 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05254

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince Georges
 City or town Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr., 11 mos., 22 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 1 yr., 11 mos., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1321 O. Street, N. W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

JANIE E. ROGERS

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife William A. Rogers6. (c) If alive, give age 54 years7. Birth date of deceased (mo., day, yr.) April 21, 1900

8. AGE: Years 47 Months 47 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Wilmington, Delaware
(Town, county, and state)10. Usual occupation File Clerk11. Industry or business - -12. Name William H. Shaw13. Birthplace North Carolina14. Maiden name Zenoma Hines15. Birthplace Virginia16. Informant Deceased

Address _____

17. Removal Date thereof June 14, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Jackson, S.C.18. Funeral director W. W. Chambers Co./P.O.Address 1400 Chapin St., N.W.19. June 13, 1947 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1947, at 5:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21, 1945 to June 13, 1947and that I last saw her alive on June 13, 1947Immediate cause of death Pulmonary Tuberculosis 2 yrs 6 da.

DURATION _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Fineman MD M. D. or other _____Address Glenn Dale, Md. Date signed 6/13/47

RECEIVED

JUN 24 1947

BUREAU V. C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs., 8 mos., 28 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution? 2 yrs., 8 mos., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D. C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1556 Eads St., N. E.
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Robert N. Rose -

3. (b) Social Security Number

579-32-3399

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Separated

6. (b) Name of husband or wife..... Carrie Rose
 6. (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) April 2, 1894
 8. AGE: Years 53 Months 53 Days 2 If less than one day hrs. min.

9. Birthplace Amherst Co., Virginia
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business - - -

12. Name Patrick Rose

13. Birthplace Amherst Co., Virginia

14. Maiden name Mary Robertson,

15. Birthplace Virginia

16. Informant Deceased

Address

17. Removal Date thereof 6-4-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory.....

Location.....

18. Funeral director Malvan & Schey Inc.

Address 424 R. St. N. W.

19. 6/4 1947 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1947, at 8³⁵ a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/5 1944 to 6/4 1947
 and that I last saw him alive on 6/4 1947

Immediate cause of death Pulmonary Tuberculosis
 DURATION 4 years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

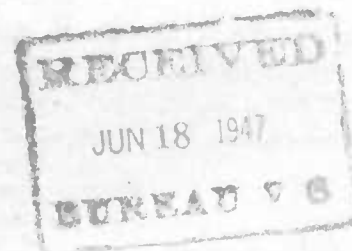
Injured at home, farm, industry, public place (where?).....

Means of Injury Injured at work?

23. SIGNATURE Daniel Leo Pinucane M.D.
 M. D. or other

Address Glenn Dale, Md. Date signed 6/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05256

183

Reg. Dist. No. 245

1. PLACE OF DEATH:

County GeoCity or town Glendale
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? transit
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Pro Geo coCity or town Glendale md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George Robert Sartain

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan 1, 1939

6. (c) If alive, give age _____ years

8. AGE:

Years 8Months 5Days 9

If less than one day

_____ hrs. _____ min.

9. Birthplace

West L.C.
(Town, county, and state)

10. Usual occupation

student

11. Industry or business

FATHER

12. Name

Clarence H. Sartain Jr

13. Birthplace

West L.C.

MOTHER

14. Maiden name

Helen Naomi Morris

15. Birthplace

md

16. Informant

Clarence H. SartainGlendale md.

17. Burial

Fort LincolnWashington D.C.Location

18. Funeral director

J. Checchi songHyattsville md.

19. Date rec'd by registrar

June 12 19 47James Sevey

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 9, 19 47 at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____, to _____ 19 _____

and that I last saw h. _____ alive on _____ 19 _____

Immediate cause of death

Asphyxiation

Due to

Drowning

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

_____ Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, "I in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

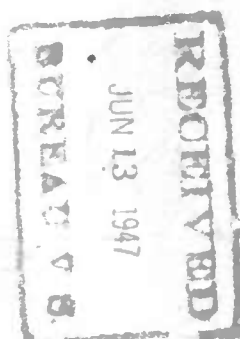
Means of injury

Injured at work?

23. SIGNATURE John J. Maloney, M.D. Acting Dep. Med. ExamChas. Hyattsville M. D. or other _____Address _____ Date signed 6-9-47

(altut singard)

Bowie 2318



M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 05257
 243
 Reg. Dist. No.

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 17 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution?..... 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D. C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 120 R. Street, N. E.
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

ALEX

3. (b) Social Security Number

SHARPE 579-09-7173

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Eva Sharp 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) January 10, 1910

8. AGE: Years 37 Months 37 Days 14 It less than one day 24 hrs. min.

9. Birthplace Wilson, North Carolina
 (Town, county, and state)

10. Usual occupation Presser

11. Industry or business

12. Name Mack Sharp

13. Birthplace Wilson, North Carolina

14. Maiden name Katie Taylor

15. Birthplace Wilson, North Carolina

Deceased

16. Informant Address

17. Removal Date thereof June 5-1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington - D.C.

18. Funeral director Hall Bros. Funeral Home

Address 621 Fla. Ave. N.W. Wash. D.C.

19. 6/5 19 47 Rowland S. Philips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4th 19 47 at 6 20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17th 19 47 to June 4th 19 47 and that I last saw him alive on June 4th 19 47

Immediate cause of death

Pulmonary Tuberculosis 7 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pincane M.D.

M. D. or other

Address Glenn Dale, Md. Date signed 6/4/47

RECEIVED
JUN 18 1947
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 05258
 Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 yrs., 8 mos., 20 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution? 5 yrs., 8 mos., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... D. C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 704 Third St., N. W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

JAMES SHEEHAN

3. (b) Social Security Number

579-07-1088

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Separated

6. (b) Name of husband or wife. Mae Snee Sheehan

6. (c) If alive, give age. 56(?) years

7. Birth date of deceased (mo., day, yr.) March 23, 1892

8. AGE: Years 55 Months 55 Days 2 If less than one day hrs. 27 min.

9. Birthplace. Cambridge, Massachusetts (Town, county, and state)

10. Usual occupation. Carpenter

11. Industry or business - - -

12. Name. Dennis Sheehan

13. Birthplace. Ireland

14. Maiden name. Margaret Aherne

15. Birthplace. Ireland

16. Informant. Deceased

Address

17. Removal to Date thereof June 20, 1947 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory. Removal June 20, 1947

Location. Washington D.C.

18. Funeral director. W. W. Chambers Co.

Address. 572-114 St. S.E.

19. June 19, 47 Rowland S. Phillips Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH. JUNE 19 1947 at 6:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT 29 41 to JUNE 19 47 and that I last saw him alive on JUNE 19 47

Immediate cause of death PULMONARY TUBERCULOSIS DURATION 8 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

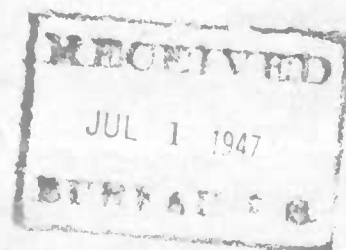
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE. Daniel Leo Pinucane MD M. D. or other

Address. Glenn Dale, Md Date signed 6-19-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

05259

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince Georges
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Island Memorial Hosp
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Colmar Manor
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4321 Monroeville St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME HENRY E. SHERFEY 3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Maudie C. 8.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) March 25, 1886
8. AGE: Years 61 Months 2 Days 10 If less than one day _____ hrs. _____ min.
9. Birthplace Brazil, Indiana
(Town, county, and state)
10. Usual occupation retired Postal Clerk
11. Industry or business U.S. Government
12. Name Joseph Sherfey
13. Birthplace Indiana
14. Maiden name Ada
15. Birthplace Indiana

16. Informant Maudie C. Sherfey
Address 4321 Monroeville St. Colmar Manor
17. Cremation Date thereof June 15, 1947
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery or crematory St. Francis Cem.
Location Maryland
18. Funeral director W.W. Chambers Co.
Address Riverdale, Md
19. June 15 1947 James Sever
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1947 at 7 A.M.
21. I CERTIFY that death occurred on the date above stated, I attended deceased from June 26 1947 to June 15 1947
and that I last saw him alive on June 11 1947
Immediate cause of death coronary occlusion DURATION 1 hour
Due to coronary occlusion unknown
Due to arteriosclerosis unknown
Other conditions _____
(Include pregnancy within 8 months of death)
Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE Henry G. Andley M.D.
Address 1251 4th St Date signed June 15 47

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

HENRY E. SHERREY

RECEIVED

JUN 17 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

CERTIFICATE OF DEATH

 05260
 231
 Reg. Dist. No.

1. PLACE OF DEATH:

County Pro Geo County
 City or town Cheverly Md Pro Geo Hospital
 (If outside city or town limits, write RURAL and give nearest town)
Dead on arrival
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington D. C. County
 City or town Washington D. C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4500 Livingston Rd S E Apt A
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Ardyce Lorraine Simon

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife
 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1922
 8. AGE: Years 25 Months Days If less than one day
 hrs. min.

9. Birthplace Cylon Wisconsin
 (Town, county, and state)

10. Usual occupation Nurse

11. Industry or business St Elizabeths Hospital

12. Name Earl J. Simon
 13. Birthplace Wisconsin

14. Maiden name Nellie Denger
 15. Birthplace Wisconsin

16. Informant Floyd J. Simon
 Address 4115 Ohio st Omaha, Neb.

17. transportation Date thereof June 18, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Frederic Cemetery
 Location Frederic Wisconsin

18. Funeral director F. Gasch's Sons
 Address Hyattsville Maryland.

19. 6/17 1947 Amanda Downey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1947 at 3:14 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death DURATION

hemorrhage and
fracture of base
of skull
 Due to
 Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6-16-47

Where did injury occur? Pin fell and (City or town) (County) (State)

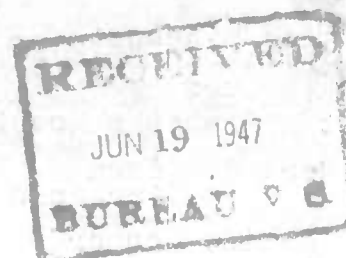
Injured at home, farm, industry, public place (where) Cross Highway

Means of injury in auto that struck gas object (Means of injury) (Place of injury)

heaps of wreckage

23. SIGNATURE Forestelli M. D. or other

Address Forestelli Date signed 6-17-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

9402

05261

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:

County Prince George
 City or town Mt. Rainier
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2.5 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George
 City or town Mt. Rainier
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4009 - 31st St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Frank B. Smith

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Earline E.
 6.(c) If alive, give age 59 years
 7. Birth date of deceased (mo., day, yr.) April 28, 1888
 8. AGE: Years 59 Months 1 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace St. Paul, Minn.
 (Town, county, and state)

10. Usual occupation Publisher

11. Industry or business

FATHER 12. Name Shelby S. Smith
 13. Birthplace North Dakota
 MOTHER 14. Maiden name Eliz. Bishop
 15. Birthplace North Dakota

16. Informant Shelby Smith
 Address 4307 - Claggett Rd. Arundel, Md.

17. Burial Date thereof 6-13-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery
 Location 3201 - Bladensburg Rd. Colmar Manor, Md.

18. Funeral director Wm. G. Nalley
 Address 3200 - R.I. Ave. Mt. Rainier, Md.

19. June 12 1947
 (Date rec'd by registrar) Registrar Mrs. Jas. Severe
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1947, at 1:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____, and that I last saw him _____ alive on _____ 19_____

Immediate cause of death _____

Coronary Occlusion Sudden

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John W. Maloney Acting Dep. Med. Exam

Address Cherry Hill Date signed 6-10-47

RECEIVED
JUN 13 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05262

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 18 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution?..... 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D. C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1609 13th St. N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

HAROLD SYMONETTE JR.

3. (b) Social Security Number

4. Sex..... Male
 5. Color or race..... Colored
 6. (a) Single, married, widowed, or divorced..... Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... November 9, 1919
 6. (c) If alive, give age..... years

8. AGE: Years..... 27 Months..... 7 Days..... 16 If less than one day..... hrs. min.

9. Birthplace..... Washington, D. C.
 (Town, county, and state)

10. Usual occupation..... Houseman

11. Industry or business.....

MOTHER FATHER
 12. Name..... Harold Symonette
 13. Birthplace..... Bohama Island
 14. Maiden name..... Jennie Moore
 15. Birthplace..... ? Alabama

16. Informant..... Deceased

Address.....

17. Removal Date thereof..... 6/25/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... Washington - D. C.

18. Funeral director..... S. E. Murray & Son

Address..... 1337-10th St. N.W.

19. June 25, 1947 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 6/25/47, at 9:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/6/47 to 6/25/47

and that I last saw him alive on 6/25/47

Immediate cause of death..... Pulmonary Tuberculosis

DURATION 2 months

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Finckel MD

M. D. or other

Address..... Glenn Dale, Md. Date signed..... June 25, 1947

RECEIVED

JUL 5 1947

BUREAU F. B. I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince GeorgeCity or town Friendly, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Friendly
(If outside city or town limits, write RURAL and give nearest town)Street No. 7800-Old Fort Rd., S.E.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

CLARA E. TAYLOR

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

White

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 20th 18898. AGE: Years 57 Months Days If less than one day
hrs. min.9. Birthplace Friendly, Maryland
(Town, county, and state)
None

10. Usual occupation

11. Industry or business

12. Name William F. Taylor13. Birthplace Md.14. Maiden name Sarah E. Thorne15. Birthplace Md.16. Informant Mrs. Irma WockleyAddress 7810-Old Fort Rd., S.E.17. Friendly, Md. Date thereof July 1st 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Providence M. E. CemeteryLocation Friendly, Maryland16. Funeral director Arthur E. Simmons Jr.Address 2007 Nichols Ave S.E.
Washington19. June 28 19 47 Howard J. Beall
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28th 19 47 at 10:00P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/3 19 47 to 6/28 19 47
and that I last saw him alive on 6/28 19 47Immediate cause of death Pulmonary hemorrhage

DURATION

4 hrDue to Concussion of lung6 mo

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles F. Indley M. D. or otherAddress 2220 Nichols Date signed 6/28

RECEIVED

JUL 5 1947

DEPT. OF JUSTICE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

182

05264

CERTIFICATE OF DEATH

Reg. Dist. No.

234

1. PLACE OF DEATH:

County Prince Georges mdCity or town Allentown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pr. Geo County Pr. GeoCity or town Allentown
(If outside city or town limits, write RURAL and give nearest town)Street No. 6040 - Brock Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Infant (unnamed) Thompson

3. (b) Social Security Number

4. Sex

F

5. Color or race

C

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of
deceased (mo., day, yr.)20 days

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

20

hrs.

min.

9. Birthplace

Washington, DC
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

June 10 - '47
(month) (day) (year)

Cemetery or crematorium

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

47 Mrs. Alton Davis
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 919. 47

at

6 A.

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h. alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, "I in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John W. Maloney M.D.
M. D. or other

Address

Hyatonsville, Md

Date signed

4-9-47

RECEIVED

JUN 12 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05265

Reg. Dist. No. *nf5*

1. PLACE OF DEATH:

County *Prince George*

City or town *Riverdale Md.*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Leland Memo.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Washington D.C.* County *D.C.*

City or town *767 7th St D.C.*
(If outside city or town limits, write RURAL and give nearest town)

Street No. *767 7th St D.C.*
(If rural, give LOCATION)

2.(a) If veteran, name war *none*

3. (a) FULL NAME

LOLO ARBINE THOMPSON

3. (b) Social Security Number

none

4. Sex *Female* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband or wife *William L. Thompson*

7. Birth date of deceased (mo., day, yr.) *April 2nd 1905* 6. (c) If alive, give age *42* years

8. AGE: Years *42* Months *0* Days *0* If less than one day *0* hrs. *0* min.

9. Birthplace *Alex. Va.*
(Town, county, and state)

10. Usual occupation *none*

11. Industry or business *none*

12. Name *George P. Ames*

13. Birthplace *Maine*

14. Maiden name *Mora Stanton*

15. Birthplace *New Jersey*

16. *Mr William L. Thompson*

Address *767 7th St D.C.*

17. *Burial* Date thereof *6-7-47*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Greenwood*

Location *Washington D.C.*

18. Funeral director *W.W. Chambers Co*

Address *517 11th St D.C.*

19. *June 7 1947* Registrar *Ms. S. S. S.*

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *June 7 1947* at *4:45 a.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Apr 13 1942* to *June 7 1947*

and that last saw him alive on *June 6 1947*

Immediate cause of death *Cerebral Hemorrhage*

Due to *cerebral arteriosclerosis*

hypertension

Due to *glomerular nephritis*

Other conditions *unknown*

(Include pregnancy within 3 months of death)

Major findings of operations *none*

Date of op. *none*

Autopsy results *none*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *none* Date of *none*

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury *none* Injured at work?

23. SIGNATURE *Stanton G. Hadley*

Address *none* Date signed *June 7 1947*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 10 1947

BUREAU V &

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

05266

1. PLACE OF DEATH

County

Prince Georges

Registration Dist. No.

243

Village or City

Hillside

No.

1323-56th Ave.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred

2 yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

2. FULL NAME

John Iron

If U. S. Veteran, specify WAR

(a) Residence: No.

1323-56th Ave., Hillside, Md.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
married

5a. If married, widowed, or divorced

HUSBAND or (or) WIFE of

Frances Iron

6. DATE OF BIRTH (month, day, and year)

January 19, 1864

7. AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

83

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

Gardener

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

Gardener

10. Date deceased last worked at this occupation (month and year)

1927

11. Total time (years) spent in this occupation

20

12. BIRTHPLACE (city or town)

Ferrara Province

(State or country)

Italy

13. NAME

Peter Iron

FATHER

14. BIRTHPLACE (city or town)

Ferrara Province

(State or country)

Italy

15. MOTHER NAME

Mary Maddalena Breeze

16. BIRTHPLACE (city or town)

Ferrara Province

(State or country)

Italy

17. INFORMANT

Mrs. L. A. Sullivan

(Address)

1323-56th Ave., Hillside, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place

Removal Valhalla, N.Y.

Date

June 15, 1947

19. UNDERTAKER

W. W. Chambers Co.

(Address)

617-114 St., S.E.

20. FILED

June 18, 1947

Carrie J. Campbell

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

June

(Month)

14

(Day)

1947

(Year)

22.

I HEREBY CERTIFY, That I attended deceased from

May

30

19

to

June

14

19

to

June

14

1947

I last saw him alive on June 14, 1947; death is said

to have occurred on the date stated above, at 2 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary Thrombosis

Date of onset

15 days

(Count back 30

days)

1947

Other Contributory Causes of Importance:

Generalized arteriosclerosis

15 years

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of Injury

19

Where did Injury occur?

(Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

William Brannon

M. D.

(Address) 614 Central Ave., Capitol Hill, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1642

05267

231

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Prince George'sCity or town Arden Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7191 Tucker Road

(If rural, give LOCATION)

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Arden Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7191 - Tucker Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Walter F. Lumley

3.(b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29, 1888

8. AGE: Years Months Days If less than one day

58 hrs. min.9. Birthplace North Carolina

(Town, county, and state)

10. Usual occupation machinist11. Industry or business Naval Gun Factory12. Name Mathias J. Lumley13. Birthplace South Carolina14. Maiden name Rodneya Holcomb15. Birthplace North Carolina16. Informant Mathias J. LumleyAddress 813 - Piedmont Ave. Winston-Salemtransportation Date thereof 6/22/47

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematorium Winston-SalemLocation North Carolina18. Funeral director F. G. G. G. G. G.Address Winston-Salem, N.C.19. 6/22 19 47 Amanda Downey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 19 47 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to.....19.....

and that I last saw him alive on.....19.....

Immediate cause of death

demonstrable andshockDue to gun-shot woundof head

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 6-21-47Where did injury occur? Arden Hill (City or town) P.G. (County) MD (State)Injured at home, farm, industry, public place (where?) HomeManner of injury that was in head and neckReput. Medical Examiner23. SIGNATURE Mathias J. Lumley M. D. or otherAddress Winston-Salem Date signed 6-22-47

RECEIVED

JUN 25 1947

BUREAU V G

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05268

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 1 mo., 24 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution?..... 1 mo., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... D. C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3204 Varnum St., N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

GENEVIEVE WHALEN

3. (b) Social Security Number

4. Sex..... Female
 5. Color or race..... White
 6.(a) Single, married, widowed, or divorced..... Single
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... July 25, 1901
 8. AGE: Years..... 45 Months..... 45 Days..... 25 If less than one day..... hrs. min.
 9. Birthplace..... Salem, West Virginia
 (Town, county, and state)
 10. Usual occupation..... Secretary
 11. Industry or business.....

FATHER
 12. Name..... John Whalen
 13. Birthplace..... Salem, West Virginia
 MOTHER
 14. Maiden name..... Anna Boyle
 15. Birthplace..... Salem, West Virginia

16. Informant..... Deceased
 Address.....

17. Removal..... Date thereof..... 6-19-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium.....
 Location.....
 18. Funeral director..... Jos & Burghis Sons
 Address..... 3034 Mt. Airy Rd.
 19. June 19, 47 Rowland S. Philips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 19, 1947, at 4:15 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 25, 1947, to June 19, 1947, and that I last saw her alive on June 19, 1947.

Immediate cause of death..... Pulmonary Tuberculosis
 DURATION..... 3 yrs

Due to.....
 Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE..... Daniel Leo Pinucane MD.
 M. D. or other
 Address..... Glenn Dale, Md. Date signed 6/19/47

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JUN 24 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05269

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince George
 City or town Lanham
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Prince George
 City or town Lanham
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 608 9th St
 (If rural, give LOCATION)
 2. (a) If veteran, name war World war 2

3. (a) FULL NAME

Lester James Wilson

3. (b) Social Security Number

4. Sex Male 5. Color or race colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Bessie Wilson

7. Birth date of deceased (mo., day, yr.) May 18, 1920 6. (c) If alive, give age _____ years

8. AGE: Years 27 Months 1 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Lanham Prince George & md
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Roland Wilson13. Birthplace Lanham md14. Father's name Cornell C. Cumberwell15. Birthplace Mayland16. Informant Cornell C. CumberwellAddress 608 9th St Lanham md17. Burial Date thereof July 1, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Balto National CemeteryLocation Catonsville md18. Funeral director Ridgely SelbyAddress 401 Wash Ave Lanham md19. June 30, 1947 M. Brocheare

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1947 at 1:20 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28, 1947 to June 28, 1947and that I last saw him in bed on June 28, 1947Immediate cause of death Pulmonary TuberculosisDue to Generalized TuberculosisDue to Generalized Tuberculosis

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. M. Warren M.D.Address Lanham Date signed 6/28/47

MARGIN RESERVED FOR BINDING

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9-43-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 2 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05270
245

1. PLACE OF DEATH:

County Pr. GeorgeCity or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Pr. Geo.City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)Street No. 3503 Upshur St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William S. Wilson

3. (b) Social Security Number

4. Sex

M-

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Alice D. Wilson

7. Birth date of

deceased (mo., day, yr.)

June 21, 1888

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

591120

hrs.

min.

9. Birthplace

Kentucky

(Town, county, and state)

10. Usual occupation

Engineer

11. Industry or business

William S. Wilson

12. Name

Kentucky

13. Birthplace

?

14. Maiden name

?

15. Birthplace

?

16. Informant

Josephine Smith

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereon

June 12, 1947

Cemetery or crematory

Arlington Cemetery

Location

Arlington, Va

18. Funeral director

St. Esch's Spis

Address

Hyattsville Md.

19.

June 12, 1947

19.

James Severy

19.

19.

19.

19.

19.

19.

19.

19.

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 10

19

47

at

5 P.

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Coronary Thrombosis

DURATION

Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John J. MaloneyActing Deputy
Med. Examiner

M. D. or other

Address

Cherry - MdDate signed 6-10-47

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JUN 13 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05271 231

1. PLACE OF DEATH:

County Pr. Geo.
 City or town Chesley
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Pr. Geo. Hoops
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md. County Pr. Geo.
 City or town Naylor
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Windsor, Infant male

3. (b) Social Security Number

4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced newborn

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 6-24-47 6.(c) If alive, give age _____ years

8. AGE: Years _____ Months _____ Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Chesley, P.D. Co. Md.
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Eddie Windsor
 13. Birthplace Md.
 14. Maiden name Madeline Bruce
 15. Birthplace Missouri

16. Informant Eddie Windsor
 Address Naylor, Md.

17. Burial Date thereof 6-28-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Peters
 Location Naylor, Md.

18. Funeral director Pitche Bros
 Address Copper Harbors Md.

19. 6/28 19 47 Amanda Downey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27 19 47 at 2:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/24 19 47, to 6/27 19 47, and that I last saw him alive on 6/27 19 47.

Immediate cause of death extreme gastric dilatation
 DURATION _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE T. Christensen, M.D.

Address Cedice Park, Md. Date signed 6/27/47

RECEIVED

JUL 2 1947

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

05272

1. PLACE OF DEATH:

County Prince GeorgesCity or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 days

Hospital, institution, or street address where death occurred:

Prince Georges General HospitalHow long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Suitland Road
(If outside city or town limits, write RURAL and give nearest town)Street No. 5901
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Evelyn V. Hood

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-23-19058. AGE: Years Months Days If less than one day
42 3 29 hrs. min.9. Birthplace Washington D.C.
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

12. Name Art Burdick13. Birthplace Maryland14. Maiden name Lillian A. Mink15. Birthplace Illinois

16. Informant

Address

17. Burial Date thereof June 23-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetary or crematory St Barnabas CemeteryLocation Suitland 2nd Ave. Hill18. Funeral director Arthur E. SimmonsAddress 2007-Nichols Ave S.E. Wash D.C.19. 6/20 19 47 Amanda Hood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 19 47, at 47 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 19 47 to June 20 19 47 and that I last saw him alive on June 19 19 47Immediate cause of death Diffuse hepatitis with
liver necrosis
Due to Septic infection unknownDue to
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations HepatitisAutopsy results Liver necrosis - summary report
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE George H. McFain, M.D.
M. D. or otherAddress 1746 K. N. W. Wood Date signed June 20-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Apix 30 m. ft

